

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6493

## CERTIFICATE OF DEATH

Reg. Dist. No.

06391

191

1. PLACE OF DEATH o. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Convalescent Home</b>		d. STREET ADDRESS <b>1524 Pentwood Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>BETTIE</b> Middle <b>T.</b> Last <b>BOYLES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James D. Mansfield</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Price</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Wm. H. Pridham - 1524 Pentwood Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Aneurysm</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic CV disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>amb</b> <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>56</b> , to <b>June 2</b> , 19 <b>57</b> , that I lost saw the deceased olive on <b>June 1</b> , 19 <b>57</b> , and that death occurred at <b>90</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MAIN ST</b> DATE SIGNED ACTUAL SIGNATURE <b>Dr. L. A. Kochman</b> M.D. <b>Ellicott City - Md</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Vickner &amp; Sons - Balt</b>		24a. REC'D BY REGISTRAR <b>DATE 6/6/57</b>	
24b. REGISTRAR'S SIGNATURE <b>J. E. Loughran</b>			

JUN 2 1957

RECEIVED

## Reg. Dist. No.

**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 9/55

may be retained by the hospital or attending physician.  
**3. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. BARTHOLOMEW		M		37		1920		BALTIMORE, MARYLAND		CLOCK REPAIRER	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
JUNE 20, 1957		BALTIMORE, MARYLAND		HEART DISEASE		SUICIDE		CORONARY THROMBOSIS		DR. J. H. BARTHOLOMEW	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
JAMES H. BARTHOLOMEW		J. H. BARTHOLOMEW		J. H. BARTHOLOMEW		J. H. BARTHOLOMEW		J. H. BARTHOLOMEW		J. H. BARTHOLOMEW	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JUNE 20, 1957		JUNE 20, 1957		JUNE 20, 1957		JUNE 20, 1957		JUNE 20, 1957		JUNE 20, 1957	

BUREAU V. 2

JUN 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6495

## CERTIFICATE OF DEATH

Reg. Dist. No.

98393

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Elkridge</u>	
c. LENGTH OF STAY IN 1b <u>10 yr.</u>		d. STREET ADDRESS <u>16417 Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6417 Washington Blvd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John E Hanes</u> First Middle Last		4. DATE OF DEATH <u>June 28 1957</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18 76</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hanes</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-6708</u>	
17. INFORMANT <u>Helen Smithson</u>		Address <u>6417 Washington Blvd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Teff Hemiplegia</u> DUE TO (c) <u>General arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Senility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 23, 1957</u> , to <u>June 23, 1957</u> , that I last saw the deceased alive on <u>June 25, 1957</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1609 41st St</u> DATE SIGNED <u>BB Brumbaugh</u>			
ACTUAL SIGNATURE <u>BB Brumbaugh</u> M.D.			
PHYSICIAN'S NAME (Type) <u>BB Brumbaugh</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Oliver</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Aitz</u>		24a. REC'D BY REGISTRAR <u>JUL 1 1957</u>	
ADDRESS <u>814 W 36 St. Balt 11 Md</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Loughery</u>	

BUREAU V. S.

JUL 2 1957

RECEIVED

6426

## CERTIFICATE OF DEATH

Reg. Dist. No.

110

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5438 Race Road</u>				d. STREET ADDRESS <u>5438 Race Road</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Grant Hawkins</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1865</u>	9. AGE (In years last birthday) yrs. <u>92</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Walker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Claudann ? ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Frank Hawkins-5438 Race Road-Elkridge MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>Chronic Myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 14, 1957</u> , to <u>June 15, 1957</u> , that I last saw the deceased alive on <u>June 14, 1957</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1609 Main St</u> DATE SIGNED <u>6/17/57</u>							
ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.				DATE SIGNED <u>6/17/57</u>			
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>				<u>Elkridge Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holland Funeral Home-1631 Druid Hill Ave</u>				24a. REC'D BY REGISTRAR <u>JUN 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>E. R. Williams</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 2

JUN 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15/ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
Item 18 Film 217 6 25 57 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
Reg. Dist. No. 06395/90																			
1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge 27</b>					c. LENGTH OF STAY IN 1b <b>23 yrs</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge 27</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bot 250 Washington Blvd.</b>					d. STREET ADDRESS <b>Bot 250 Washington Blvd.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>W.</b> Last <b>JOHNSON</b>					4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 57</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/10/1894</b>		9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>					11. BIRTHPLACE (State or foreign country) <b>Maryland, BALTO.</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Peter Johnson</b>					14. MOTHER'S MAIDEN NAME <b>Emily Schaeffer</b>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I 213-10-7334</b>					17. INFORMANT Address <b>Fred. C. Johnson, Elkridge, Maryland</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Paul R. Guerin</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Paul R. Guerin, M.D.</b>										DATE SIGNED <b>6/14/57</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>6/17/57</b>					22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cgm.</b>					22d. LOCATION (City, town, or county) (State) <b>Waterloo Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Lowmush</b>					ADDRESS <b>95 S. S. S. S.</b>					24a. REC'D BY REGISTRAR <b>JUN 17 1957</b>					24b. REGISTRAR'S SIGNATURE <b>Edmund Williams</b>				

BUREAU V. S.

JUN 17 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6498

## CERTIFICATE OF DEATH

06396

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEENWOOD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEENWOOD x0</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>F</u> Last <u>KERGER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 1, 1875</u>	
9. AGE (In years last birthday) yrs. <u>82</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE CO MD</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>STEPHEN KERGER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH TRAMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>58170</u>		17. INFORMANT <u>W F KERGER JR. CLEENWOOD MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL Arrest, Arteriosclerotic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Disease, Arteriosclerosis generalize,</u> DUE TO (c) <u>Cirrhosis of Liver,</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>58170</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>54</u> to <u>27 June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>27 June</u> , 19 <u>57</u> , and that death occurred at <u>3:15 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				DATE SIGNED <u>27 June 57</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD E HALL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. LOUIS</u>		22d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. HIGGINS</u>				ADDRESS <u>ELICOTT CITY MD</u>		24a. REC'D BY REGISTRAR <u>DATE 1 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Outreach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 10-5-28
SEX Male		AGE 29
RACE White		RELIGION Methodist
MARRIAGE Single		EDUCATION High School
OCCUPATION Salesman		RESIDENCE 1000 N. 1st St., Memphis, Tenn.
PLACE OF DEATH Memphis, Tenn.		CAUSE OF DEATH Shot
MANNER OF DEATH Suicide		DATE OF DEATH 4-4-68
SIGNATURE OF PHYSICIAN J. Edgar Hoover		DATE 4-4-68
SIGNATURE OF CORONER J. Edgar Hoover		DATE 4-4-68
SIGNATURE OF WITNESS J. Edgar Hoover		DATE 4-4-68

BUREAU V. 3

JUL 1 1967

RECEIVED

6409

## CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH o. COUNTY <u>Howard Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Howard Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkchester Howard Co</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Elkchester Road</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George E Lohrig</u>				4. DATE OF DEATH <u>6/1/57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/3/98</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housew.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Green House</u>			
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Jacob P Lohrig</u>				14. MOTHER'S MAIDEN NAME <u>Anna May Hartenstein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XXX-1</u>				16. SOCIAL SECURITY NO. <u>XXX-1</u>			
17. INFORMANT <u>Mrs Marie Lohrig</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 years</u> DUE TO <u>Hypertensive Cardio-Vascular Disease</u> (c) <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/3/49</u> , 19 <u>57</u> , to <u>6/1/57</u> , that I last saw the deceased alive on <u>3/12/57</u> , 19 <u>57</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William T. Lassaway</u>				ADDRESS (Street, city or town, state) <u>Elkchester Rd, MD</u>			
PHYSICIAN'S NAME (Type) <u>William T. Lassaway</u>				DATE SIGNED <u>6/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE, THEREOF <u>6/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		22d. LOCATION (City, town, or county) (State) <u>Baeto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall &amp; Son</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>JUN 5 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Edith Williams</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06398

6410

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howard</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel 16412</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>318 Thomas Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALLEGRA SANBURN LOVE</u>		<b>4. DATE OF DEATH</b> <u>June 30</u> 19 <u>57</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Mar-9-1956</u>
<b>9. AGE</b> (In years last birthday) yrs. <u>7</u> Months <u>21</u> Days <u></u> Hours <u></u> Min. <u></u>		<b>10. BIRTHPLACE</b> (State or foreign country) <u>Laurel, Md</u>	
<b>11. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Richard B. Love Jr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Francesca Phillips</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u></u>	
<b>17. INFORMANT</b> <u>Richard B. Love Jr.</u>		<b>Address</b> <u>Laurel, Md</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> <u>756.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Encephalitis</u> DUE TO (c) <u>Complication of Stomach &amp; Bile Ducts</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <u>March 1956</u> to <u>June 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>57</u> , and that death occurred at <u>2:00</u> P. M. from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Robert C. Wingfield</u>		<b>DATE SIGNED</b> <u>June 30, 1957</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>ROBERT C. WINGFIELD</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>	<b>22b. DATE THEREOF</b> <u>7/1/57</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>East Laurel Cem.</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Laurel, Md</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>De Witt Handman</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Jul 5 57</u>	
<b>ADDRESS</b> <u>Laurel, Md</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. H. H.</u>	

2076232XV5

**BUREAU V. F.**

JUL 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06400

6411

## CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <b>Howard Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Elkridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5506 Race Rd.</b>		d. STREET ADDRESS <b>1 5506 Race Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALEX</b> Middle <b>MEYERS</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Howard Co. Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alex Meyers Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Ellen Holland</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mary Stewart 5508 Race Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241x</b> <b>Cardio Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchial Asthma</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 25, 1956</b> to <b>June 28, 1957</b> that I last saw the deceased alive on <b>June 28, 1957</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Elkridge Md.</b>	
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Elkridge Md.</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>McLofton Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>914 Kato R Williams 3228 Schuman St.</b>		24a. REC'D BY REGISTRAR DATE <b>7/2/57</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06399

6412

CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH COUNTY <u>Howard</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey,</u>	c. LENGTH OF STAY IN 1b <u>67 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Dorsey ( Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Howard Herbert Mollman</u> First Middle Last		4. DATE OF DEATH <u>June 7, 1957</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1989</u>
9. AGE (In years last birthday) <u>67 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired general contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Dorsey, Md.</u>
13. FATHER'S NAME <u>Henry Mollman</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Pamphilian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Charles H. Mollman Dorsey, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease &amp; Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>few minutes</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1st</u> , 19 <u>56</u> , to <u>June 7th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/6/57</u> , 19 <u>57</u> , and that death occurred at <u>9a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Frank E. Shipley</u>		M.D. <u>Savage, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Church</u>	22d. LOCATION (City, town, or county) (State) <u>Dorsey, Howard Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurel, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 12 1957</u>	24b. REGISTRAR'S SIGNATURE <u>E. Bird Williams</u>

BUREAU V. S.

JUN 12 1957

RECEIVED

## 6413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 4, 11, 12, 13, 14 Film G217 6-24-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> c. LENGTH OF STAY IN 1b <b>1</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>Cissel Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLEVELAND</b> Middle <b>PARGO</b> Last <b>?</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1915</b>
9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>31</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Road</b>	
11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>?</b>		Address <b>?</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>929.7</b> (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell into Patuxent River</b>	
20c. TIME OF INJURY Hour <b>XX</b> p. m. <b>3:45</b> Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Patuxent River</b>	20f. (City or town) <b>Laurel</b> (County) <b>Howard</b> (State) <b>Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>George E. Burgtorf</b>		DATE SIGNED <b>6-1-1957</b>	
EXAMINER'S NAME (Type) <b>George E. Burgtorf M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. G. M. Anthony Board</b>		ADDRESS <b>29 S. G. road</b>	
24a. REC'D BY REGISTRAR <b>6/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Earl R. Mullen</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JUN 19 1957

RECEIVED

6414

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>Ellicott City</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Lark Brown Road</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Lark Brown Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EMMA SEEBOLD</b> First Middle Last				4. DATE OF DEATH <b>June 28, 1957</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 24, 1868</b>	
9. AGE (In years, last birthday) <b>89</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>John Miegel</b>			
14. MOTHER'S MAIDEN NAME <b>?</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Adelaide A. Schanken, Ellicott City, Md</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Asthma</b> <b>434.2</b> DUE TO <b>Ch. Myocardial Insuff. -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility -</b> (c) <b>Senility -</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>?</b> <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.2</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>6/28/57</b> , to <b>6/28/57</b> , that I last saw the deceased alive on <b>6/28/57</b> , and that death occurred at <b>1399</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank E. Shipley, M.D.</b>				ADDRESS (Street, city or town, state) <b>Savage, Ind.</b> DATE SIGNED <b>6/29/57</b>			
PHYSICIAN'S NAME (Type) <b>Frank E. Shipley, M.D., Savage, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Dorsey, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b> ADDRESS				24. REC'D BY REGISTRAR <b>JUL 1 1957</b> 24b. REGISTRAR'S SIGNATURE <b>J.E. Lougherans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John W. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 15, 1880</i></p>		<p>4. Date of death: <i>Jul 1, 1957</i></p>	
<p>5. Place of birth: <i>Worcester, Mass.</i></p>		<p>6. Place of death: <i>Worcester, Mass.</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>Dr. J. W. Smith</i></p>		<p>10. Signature of registrar: <i>John W. Smith</i></p>	
<p>11. Signature of informant: <i>John W. Smith</i></p>		<p>12. Signature of witness: <i>John W. Smith</i></p>	

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JUL 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6415

## CERTIFICATE OF DEATH

06443

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>1 Balto. St.</u>	
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>Shirley</u> Last <u>Swann</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen.</u>	
11. BIRTH PLACE (State or foreign country) <u>Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. McKnew</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Frank Shipley, M.D., Savage, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uraemia</u> <u>592X</u> DUE TO <u>Ch. Interstitial Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 56</u> to <u>June 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		DATE SIGNED <u>Savage, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>		<u>Savage, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canalehan</u>		24. REC'D BY REGISTRAR <u>18 St. W.</u> REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED: <i>John Doe</i></p>	
<p>AGE: <i>45</i></p>	
<p>SEX: <i>Male</i></p>	
<p>DATE OF DEATH: <i>June 15, 1957</i></p>	
<p>PLACE OF DEATH: <i>Home</i></p>	
<p>CAUSE OF DEATH: <i>Heart Disease</i></p>	
<p>DATE OF BIRTH: <i>January 1, 1912</i></p>	
<p>PLACE OF BIRTH: <i>Massachusetts</i></p>	
<p>DATE OF MARRIAGE: <i>March 10, 1935</i></p>	
<p>PLACE OF MARRIAGE: <i>Church</i></p>	
<p>DATE OF INTERMENT: <i>June 18, 1957</i></p>	
<p>PLACE OF INTERMENT: <i>Cemetery</i></p>	
<p>DATE OF BURIAL: <i>June 18, 1957</i></p>	
<p>PLACE OF BURIAL: <i>Cemetery</i></p>	
<p>DATE OF CREMATION: <i>June 18, 1957</i></p>	
<p>PLACE OF CREMATION: <i>Crematorium</i></p>	
<p>DATE OF EXHUMATION: <i>None</i></p>	
<p>PLACE OF EXHUMATION: <i>None</i></p>	
<p>DATE OF REINTERMENT: <i>None</i></p>	
<p>PLACE OF REINTERMENT: <i>None</i></p>	
<p>DATE OF RECREMATION: <i>None</i></p>	
<p>PLACE OF RECREMATION: <i>None</i></p>	
<p>DATE OF REEXHUMATION: <i>None</i></p>	
<p>PLACE OF REEXHUMATION: <i>None</i></p>	
<p>DATE OF REINTERMENT: <i>None</i></p>	
<p>PLACE OF REINTERMENT: <i>None</i></p>	
<p>DATE OF RECREMATION: <i>None</i></p>	
<p>PLACE OF RECREMATION: <i>None</i></p>	
<p>DATE OF REEXHUMATION: <i>None</i></p>	
<p>PLACE OF REEXHUMATION: <i>None</i></p>	

BUREAU V. S.

JUN 18 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6416 Item 1 Film 0217 6-24-57 et CERTIFICATE OF DEATH

Reg. Dist. No.

06404

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b. <u>3 y 0 1-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mrs. Hinkson's Home</u>		d. STREET ADDRESS <u>4017 Rosecrest Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>M.</u> Last <u>Thaler</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/157</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>3 1/2</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Thaler</u>		14. MOTHER'S MAIDEN NAME <u>Virian Smelkinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Herbert Thaler - 4017 Rosecrest Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transition</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hydrocephalus - &amp;</u> (c) <u>meningomyelocoele -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>751x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/28</u> , 1957, to <u>6/17</u> , 1957, that I last saw the deceased alive on <u>June 1</u> , 1957, and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene O. Goldstein</u>		ADDRESS (Street, city or town, state) <u>700 Reidstown Rd. Baltimore Md.</u>	
PHYSICIAN'S NAME (Type) <u>EUGENE O. GOLDSTEIN</u>		DATE SIGNED <u>6/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington, Chyik, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sal Harrison &amp; Sons 1124-26 W. North Ave.</u>		24a. REC'D BY REGISTRAR <u>JUN 18 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

2047325XV5

CERTIFICATE OF DEATH

5/25/57

Hydrocephalus  
Meningocele

BUREAU N. 5

JUN 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 5/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06405

Reg. Dist. No.

190

6417

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>Ellicott City</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 175 Jonestown</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Jonestown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>HANNAH LOUISE WILSON</b>			4. DATE OF DEATH Month Day Year <b>June 13, 1957 19</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1951</b>	9. AGE (In years last birthday) <b>6</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>6 13 19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
13. FATHER'S NAME <b>John Wilson</b>			14. MOTHER'S MAIDEN NAME <b>Rosie Jones</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Lillian Jones, Ellicott City, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration brain &amp; fractured skull</b> DUE TO (b) <b>automobile accident</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <b>Fracture right humerus, radius &amp; ulna, left chest cage</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Fracture right humerus, radius &amp; ulna, left chest cage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Instant.</b> <b>Instant.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>struck by automobile</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a.m. <b>June 13, 1957</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STREET-RT 175-ELLICOTT CITY-HOWARD-MD</b>	
20f. (City or town) (County) (State) <b>ELICOTT CITY</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>CHARLES C WHITAKER</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. STEPHEN'S</b>	
22d. LOCATION (City, town, or county) (State) <b>ELICOTT CITY MD</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. C. HIGGINBOTHAM</b>			24. REGISTRAR'S SIGNATURE <b>ELICOTT CITY MD</b>		

24a. REGISTRAR'S SIGNATURE  
**JUN 17 1957**

24b. REGISTRAR'S SIGNATURE  
**Ellicott City**

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REPORT OF

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REPORT OF

Illinois City

REPORT OF

Illinois City

REPORT OF

BUREAU V. S.

JUN 17 1957

RECEIVED